

Georgia State University

ScholarWorks @ Georgia State University

GHPC Articles

Georgia Health Policy Center

7-1-2013

Leading through health system change: A public health opportunity - Planning tool

Georgia Health Policy Center

National network of public health institute

Follow this and additional works at: https://scholarworks.gsu.edu/ghpc_articles

Recommended Citation

Georgia Health Policy Center and National network of public health institute, "Leading through health system change: A public health opportunity - Planning tool" (2013). *GHPC Articles*. 98.
https://scholarworks.gsu.edu/ghpc_articles/98

This Article is brought to you for free and open access by the Georgia Health Policy Center at ScholarWorks @ Georgia State University. It has been accepted for inclusion in GHPC Articles by an authorized administrator of ScholarWorks @ Georgia State University. For more information, please contact scholarworks@gsu.edu.



Leading through Health System Change:

A Public Health Opportunity

Maternal and Child Health Module

*The National MCH Workforce Development Center
Georgia Health Policy Center at Georgia State University
National Network of Public Health Institutes*



National **MCH** Workforce
Development Center
Advancing Health Reform Implementation

The National MCH Workforce Development Center

The National MCH Workforce Development Center aims to create a continuum of learning and engagement opportunities for state and territorial Title V practitioners and MCH graduate and undergraduate students to develop the competencies required of contemporary public health leaders to implement the Affordable Care Act (ACA) and other health system transformations. The Center's key areas of focus are access to care, change management, systems integration, and quality improvement. Visit <http://mchwdc.unc.edu> to learn more.



Georgia Health Policy Center

The Georgia Health Policy Center (GHPC), housed within Georgia State University's Andrew Young School of Policy Studies, provides evidence-based research, program development, policy guidance, and technical assistance. The GHPC focuses on solutions to complex issues facing health and health care today including insurance coverage, long-term services and supports, health care reform, children's health, and the development of rural and urban health systems. The GHPC is at work throughout Georgia and in more than 200 communities across the nation, helping communities advance health and well-being. Please visit www.ghpc.gsu.edu to learn more.



National Network
of Public Health Institutes

National Network of Public Health Institutes

Created in 2001 as a forum for public health institutes (PHIs), today the National Network of Public Health Institutes (NNPHI) convenes its members and partners at the local, state, and national levels in efforts to address critical health issues. NNPHI's mission is to support national public health system initiatives and strengthen PHIs to promote multi-sector activities resulting in measurable improvements of public health structures, systems, and outcomes. Learn more about NNPHI and its member institutes at www.nnphi.org.



National **MCH** Workforce Development Center

Advancing Health Reform Implementation

This guided practice was developed in partnership with the National MCH Workforce Development Center. The Center aims to create a continuum of learning and engagement opportunities for state and territorial Title V practitioners and MCH graduate and undergraduate students to develop the competencies required of contemporary public health leaders to implement the Affordable Care Act (ACA) and other health system transformations. The Center's key areas of focus are access to care, change management, systems integration, and quality improvement. The Center's definition of health transformation is broad and applies to all states and territories as they respond to various forms of health system reform:

Health transformation shifts the emphasis of health care from disease management to prevention and population health management, while improving access to affordable health care; develops an interprofessional/interdisciplinary approach to health care; integrates primary care, specialty care and public health; develops efficient health systems that better incorporate ongoing quality improvement; and drives partnerships across sectors to optimize the well-being of maternal and child health populations.

This module is designed to assist state and territorial Title V agencies as they plan and implement health programs in an environment of health transformation. The online version is available at www.acaplanningtool.com.

The National MCH Workforce Development Center is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UE7MC26282 for \$1,837,391 with no support from nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Table of Contents

Planning Tool Road Map	1
Introduction	2
Using this Planning Tool	2
Health Reform 101	3
Looking at Health Reform through an Adaptive Lens.....	5
Putting Adaptive Thinking into Action	6
Maternal and Child Health Module	7
Step 1	7
Step 2	7
Your Turn	10
Step 3	11
Your Turn	15
Step 4	16
Your Turn	18
Step 5	20
Your Turn	21
Bibliography.....	24

Planning Tool Road Map

Determine the following:

People

Who? Leader? How to convene?

Time

Start? Duration? Frequency?

Data

Source? Who? How shared?

Tool

Use online tool or workbook version?

Introduction

- Using the Planning Tool
- Health Reform 101
- Looking at Health Reform through an Adaptive Lens
- Putting Adaptive Thinking into Action

Complete the guided practice:

Maternal and Child Health Module

- ? Define Your Question: How can Title V professionals identify and monitor improvements to maternal and child health outcomes resulting from health system transformation?
- Collect Information
- Select an Option
- Apply Adaptive Actions
- Create a Simplified Implementation Plan

Print Plan and Begin Implementation

Repeat with another Guided Practice Question, or use the 5-step process with your own question

Introduction

The changes inherent in the Affordable Care Act (health reform) have extensive implications for all aspects of the U.S. health system: financing, service delivery, public health, coverage and access, quality, and ultimately, well-being. During this critical period of health system transformation, public health has the opportunity to address both technical and adaptive challenges, think systemically, and begin to lay the groundwork for strategic action and innovation.

This tool has been designed for public health practitioners at all levels to practice using adaptive thinking as they grapple with the many questions presented by health reform and health system transformation.

Using this Planning Tool

The changes facing your organization are complex and therefore, so are future options. At the core of this project is an interactive tutorial and planning tool designed to assist you, public health leaders, in learning how to apply adaptive thinking skills to the legal, administrative, and financial health reform challenges facing your organization. Through the information and exercises provided by experts from the National MCH Workforce Development Center, the Georgia Health Policy Center at Georgia State University, the National

Network of Public Health Institutes, and the Centers for Disease Control and Prevention, you will learn valuable techniques to plan for the future of public health.

Time Needed:

4 to 8 hours of time over a period of a week or two, to complete the module.

The process will likely require four to eight hours of time over a period of a week or two to complete a guided practice. Any method you prefer to complete these steps is allowed. You may work as an individual participant or as part of a team within an organization. Additionally, feel free to bring in whatever data you will need to help you respond to the questions.

This is a planning tool intended to heighten your learning capacity and leadership skills in relation to health reform and health system transformation. Central to this tool are two key components. The first component is a five-step planning process. The steps in this process are key to helping your team focus on the actions that lead to innovation and strategic thinking. The second key component is understanding technical and adaptive challenges. Technical challenges,

Health System Change?



while not “simple” are solvable. Through research and practice, effective approaches have been designed and adopted even if they require intense skill and expertise, such as architectural design. Adaptive challenges, on the other hand, are quite different. They are often being seen for the first time. There is no expert, no one with “the answer.” Solutions require both experimentation and innovation, as in the case of managing rainforest ecosystems. Learning to use the five-step planning process and an adaptive problem-solving approach are, we believe, the key to responding to this opportunity for change.

The tutorial and planning tool you are about to use is designed using a guided-practice approach. Rather than just provide the tool and instructions, you will be guided through examples where much of the background work has been provided for you. But, your team will still have to do the analysis and strategic thinking to arrive at a solution. The goal of this approach is to make the planning tool more real-world and contextual.

Once you have fully completed one of the guided practices in the tutorial and planning tool, you can repeat the exercise with another of the provided guided practices, then take the process and apply it to your own strategic planning efforts.

Key Components:

- **Five Step Planning Process:** The steps in this process are key to helping your team focus on the actions that lead to innovation and strategic thinking.
- **Technical vs. Adaptive Challenges:** Technical challenges, while not “simple” are solvable. Adaptive challenges are quite different. There is no expert, no one with “the answer.”

As you progress through the planning tool, you will document your information related to each step of the process. This opportunity will be identified with a **Your Turn** button.



At the end of each question, you will be able to print out a report that includes the question you worked on, background information related to your question, the answer you chose to address your question, the adaptive actions you used in answering your question, and an implementation plan for action. The planning tool will probably have the most benefit if you work through it with a small group of individuals who would most likely be working with you on the question in the real world.

You can complete each question all at once or break them down into more easily digestible parts depending on how much time you have available. You may also want to take a break to gather data or information that will help make answering a question more meaningful to you or your organization. As you consider each question, think about your planning in a three to five year time horizon. Remember, this planning tool is designed to help you, as a public health leader, be more effective in addressing public health questions in the context of health care reform. The commitment you bring to the work will be reflected in what you get out of it in the end.

If you are using the electronic version of this tutorial and planning tool in PDF format, two interactive functions are built into the tool:

- **Live URL links** - When cited resources are available online, the resource will have a light blue underline under the text indicating that you can click your cursor on the area and your Internet browser will be directed to the website where the resource resides. Your Internet browser setting may prevent this function from working correctly; you may need to check your browser settings. URLs can change without notice; if the embedded link does not work, the URL address may have changed. Use your search engine (e.g., Google, Bing, Yahoo) to find the new web address.
- **Interactive forms** - In the **Your Turn** sections of this planning tool, you can type your responses directly into the blank cells of the PDF. Click your cursor at any point in the blank cell. The cursor will appear in the top left corner of the cell. You will need to save the PDF file to your computer to save the text that you enter in these cells. It is recommended that you save your file with a unique file name to protect against accidentally

saving the blank form over your information. Like all documents, it is recommended that you save your work frequently. You are able to share this file with others via email or file sharing tools.

The citations in the planning tool refer to items in the bibliography, located at the end of the planning tool. The URLs listed in the bibliography are also hyperlinked, although no blue underline appears under this text. The online version of this planning tool may be accessed at www.acaplanningtool.com.

Through this project, we hope to provide you with a new conceptual framework for leading, as well as, navigating and leveraging multiple aspects of the health reform law to improve population health.

Health Reform 101

In order to plan for the future of public health, a common understanding about the key provisions of the Affordable Care Act (ACA) is needed. The ACA was signed into law in the spring of 2010. One of the goals of the ACA is to decrease the number of uninsured Americans. The Georgia Health Policy Center developed a framework to educate others about the ACA. It includes: sources of health care coverage, funding and spending, the major components of change, and a timeline.

Sources of Coverage

Non-elderly Americans obtain health insurance through their employer, individual private insurance, Medicaid/Children's Health Insurance Program, Other [Medicare (disabled or end-stage renal patients), Champus, CHAMPVA (coverage for armed forces and veterans families) and Indian Health Services], or remain uninsured. The expansion of both public and private coverage through the ACA is expected to reduce the number of uninsured by approximately 26 million Americans before 2017.¹ Major changes will occur with the addition of health insurance marketplaces and the potential expansion of Medicaid, which is now a state decision as determined by the Supreme Court in June 2012.

By 2019, it is estimated that the percentage of uninsured Americans will decrease from 18% to 10%. Approximately 56% will be covered by employer-based insurance, 2% will be covered by private insurance, 9% will be covered through health insurance marketplaces, and 19% will be covered by Medicaid, depending on individual state decisions.²

Spending and Sources of Revenue

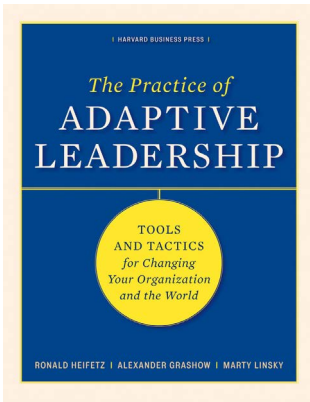
The Congressional Budget Office estimates that spending related to the ACA will be approximately \$1.8 trillion over a decade.¹ The largest share of the costs will fund the expansion of Medicaid coverage and fund the subsidies to individuals in the health insurance marketplaces. In order to remain deficit neutral, new revenues must be generated. Revenue sources include savings in Medicare (e.g., reductions to annual updates in payments and changes in the calculations for Medicare Advantage plans) and new taxes, fees, and penalties (e.g., fees for medical devices and insurers, fines/penalty payments from businesses and individuals). It is hoped that, through new models of care delivery such as Accountable Care Organizations (ACOs) and efficiencies created by vehicles such as electronic health information exchanges (e.g., through reduced duplication of services), the overall health care cost curve will begin to bend downward from its current, upward trend.

Major Components of Change

Changes in public coverage	Eligibility for Medicaid programs will be expanded to include all Americans up to 133% of the Federal Poverty Level (FPL) in states that choose to expand Medicaid coverage. The June 28, 2012 Supreme Court decision indicated that states, without penalty, could choose not to expand Medicaid. The expansion will potentially increase the number eligible for Medicaid by approximately 16 million Americans, with the largest increase being childless adults not currently eligible. The full cost of this expansion will be paid by the federal government beginning in 2014, with a phase-in of state share starting in 2017 (up to 10% of expansion costs). The federal government retains 90% of new and ongoing expansion costs beginning in 2020. The Congressional Budget Office estimates that the law will result in approximately 1.6 trillion dollars in new federal spending over the ten years to fund subsidies of private insurance and to pay for the expansion of Medicaid.
Changes in private coverage	Modifications in current insurance regulation practices include: community rating rather than risk-adjusted premiums; no pre-existing condition exclusions; no lifetime and very limited annual benefits caps; prior approval of rate increases; and a mandatory minimum medical loss ratio of 80 or 85% (by group size). The legislation also creates a high-risk pool as a bridge to provide a way to obtain coverage until other insurance market reforms are fully implemented. In addition, it mandates the creation of health insurance marketplaces, with the structure either determined by each state alone, states in partnership with the federal government, or the federal government alone, depending on what states decide to do or their readiness to act. The marketplaces will establish common rules for benefits and pricing; offer consumers a choice of plans; provide consumers information about their choices; facilitate plan enrollment; and administer the subsidies for people who earn less than 400% of the FPL.
Changes in health care quality	A variety of strategies address the need for improved quality of care: incorporating best practices and systemically collecting and analyzing health care data; streamlining and coordinating care, as well as encouraging interdisciplinary treatments; instituting a series of quality-driven incentives and penalties for providers; and funding to study and implement evidence-based practices related to the financing and delivery of Medicare. Many of these strategies focus on decreasing the overall cost of health care.
Increased focus on prevention and wellness	Efforts to improve population health and well-being will be coordinated by a national council, guided by the first-ever national prevention strategy and sustained by a dedicated prevention fund. Improvements to individual health will be supported by research and innovation and implemented through insurance coverage requirements and state and community programs. Wellness and prevention services and research will be expanded to focus on physical activity, nutrition, emotional wellness, smoking cessation, and other chronic disease priorities. Medicare and newly qualified plans will be required to provide a range of recommended preventive and wellness services in their qualified health plans, and employers will be permitted to incentivize employee participation in wellness programs. State and local agencies will be given opportunities to apply for federal funds to implement programs to create healthier communities.

Timeline

For a fully-interactive timeline with key provisions of the health reform law organized by year and searchable by topic, visit the Kaiser Family Foundation website at <http://healthreform.kff.org/Timeline.aspx>.



Harvard Business Press, 2009
ISBN #978-1-4221-5576-4

Looking at Health Reform through an Adaptive Lens

Health reform presents many opportunities for public health, but to take full advantage of these opportunities, state, local, and community leaders must be able to navigate through uncharted territory and be willing to deviate from their plans as learning takes place.

Marty Linsky and Ronald Heifetz, leaders in the field

of management consulting, write extensively about the differences between technical and adaptive challenges. While their teachings have not previously been used in the context of health reform, this planning tool employs Linsky and Heifetz' theory on adaptive leadership to provide a framework of the role public health officials must take in this environment. According to Linsky and Heifetz, technical challenges, while not simple are solvable. Through research and practice, effective approaches have been designed and adopted even if they require intense skill and expertise (such as brain surgery). Adaptive challenges, on the other hand, are quite different. They are often being seen for the first time. There is

no expert, no one with "the answer." Solutions require both experimentation and innovation. This table has examples of technical and adaptive challenges.

Health reform presents both types of challenges for public health leaders. Some are routine and technical, while others are adaptive and require planning, building partnerships, gathering information, and building capacity. According to Linsky and Heifetz in *When Leadership Spells Danger*, "a challenge for adaptive leadership is to engage people in distinguishing what is essential to preserve from their organization's heritage from what is expendable. Successful adaptations are thus both conservative and progressive. They make the best possible use of previous wisdom and know-how. The most effective leadership anchors change in the values, competencies, and strategic orientations that should endure in the organization."³ Public health leadership requires a diagnostic capacity that identifies the forces at play that constantly shape health reform. These include legal, administrative, and financial, among others.

In the next section, you will begin to put adaptive thinking into action.

Technical Challenges	Adaptive Challenges
<ul style="list-style-type: none"> Easily defined Obvious proven solution Expert to call to solve the problem Can be resolved through Standard Operating Procedures (SOPs) 	<ul style="list-style-type: none"> Hard to define No clear solution No expert who can solve the problem Perhaps new, never seen before
Examples	Examples
<ul style="list-style-type: none"> Building a hospital Fixing a broken computer Implementing health reform 	<ul style="list-style-type: none"> Eliminating poverty Reforming public education Implementing health reform

Adapted from Ronald A. Heifetz and Marty Linsky, *A Survival Guide for Leaders*

Putting Adaptive Thinking into Action

In this section of the workbook, you will practice using adaptive thinking to answer questions related to health reform by working through an example. This example was drawn from the peer-reviewed literature, national white papers, and expert review. The question is:

How can Title V professionals identify and monitor improvements to maternal and child health outcomes resulting from health system transformation?

After working through the example question, you should be able to apply a series of steps to any question you may have that does not have a ready-made solution. The steps in the process are:



Step 1: Define your question. What is it that you want to know? Is the question unique to your organization or do you think it might apply to others?



Step 2: Collect information about your question related to the Affordable Care Act and other health system transformations. What exactly is written in the law? You may have to go directly to the law or read what others have said related to the law and your question. Are there new approaches or ways of thinking about your question being practiced in other states? Chances are you will be able to learn something about your question from others. Gathering information from the law is one place to start. You may want to collect additional state and local information.



Step 3: Think about the feasible options and select one to begin your analysis. When you think about your question, what are the possible ways you could answer the question?



Step 4: Apply adaptive actions related to your question. The planning tool describes eight adaptive actions you can apply to the answer option you choose. Some might be very relevant to your work and others may not.



Step 5: Create a simplified implementation plan. This step will help you think about a concrete way to move forward related to staffing, budgeting and funding, and developing a management plan in the context of how you choose to answer your question.

There are additional guided practices available online at www.acaplanningtool.com.

MCH Module

? Step 1: Define Your Question.

How can Title V professionals identify and monitor improvements to maternal and child health outcomes resulting from health system transformation?

📁 Step 2: Collect information about your question related to the Affordable Care Act and other health system transformations.

Overview

The Affordable Care Act (ACA) provides numerous opportunities that Title V can use to improve maternal and child health. Opportunities include, but are not limited to: access to affordable health insurance, coverage of preventive care services, support for care coordination efforts, and community benefit requirements. By increasing access to affordable health insurance, women and children who were previously un- or underinsured have increased access to appropriate health care services. The requirement for insurers to cover (with no cost-sharing) certain designated preventive services for women and children further encourages and allows the public to access and utilize appropriate health care services. The ACA also provided prompting and funding for innovative care coordination and financial savings models such as Accountable Care Organizations, medical homes, home visiting programs, and community health workers; all of which have the ability to directly serve and improve maternal and child health needs. Additionally, the law created enhancement of community benefit requirements for hospitals, which can address and serve maternal and child health at the community level. Although the ACA provides many opportunities to improve maternal and child health, certain systemic gaps remain. Thus, Title V programs can embrace the new opportunities while nonetheless remaining aware of a continued need to fill those gaps.

Insurance Access

One of the main goals of the ACA was to increase the public's access to affordable health insurance. The ACA seeks to accomplish this goal by expanding Medicaid eligibility to those at or below 138% of the federal poverty limit (FPL),

extending and strengthening CHIP, creating health insurance marketplaces for the purchase of affordable health insurance, creating requirements for employer-sponsored insurance, and removing the ability of insurance companies to deny insurance coverage due to pre-existing conditions. One way Title V programs can get involved in the area of insurance access is by working with state and local partners to increase uptake of new insurance options, while still supporting direct services for those unable to obtain affordable insurance.

In June 2012, the Supreme Court determined that the ACA's Medicaid expansion provision is optional for states, rather than mandatory. To date, 28 states have chosen to expand Medicaid for US citizens and documented immigrants, at or below 138% FPL. In non-expansion states, adults (including single or married women) at or below 138% FPL must obtain insurance by other means, either through employers, health insurance marketplaces, in the private market, through parents' insurance (if under 26 and a student), or remain uninsured. However, in all states, pregnant women and children who meet the state's income and immigration requirements will still have Medicaid as an option. Additionally, the ACA provided federal funding for the Children's Health Insurance Program (CHIP) until 2015, and then maintains the program by increasing the match rate starting in 2015. The ACA's "no wrong door" initiative requires that state Medicaid departments coordinate with health insurance marketplaces to ensure that new applicants are directed to the appropriate insurance access point.

The ACA's health insurance marketplaces serve as an additional market where the public may purchase health insurance meeting minimum coverage, cost, and provider network requirements. The federal government provides a sliding scale of subsidies to customers, depending on their income level. However, undocumented immigrants, who make up an estimated 3.5% of the nation's population (11.2 million persons in 2012)⁴, may not access the subsidies. Although there are network adequacy requirements for health insurance plans to be sold on the marketplaces, many, due to cost and contracting, may not have as robust a provider and specialist network as plans obtained in the private market or through employers. Parents of children and youth with special health care needs (CYSHCN) or others requiring particular specialist care may need to pay special attention to this when purchasing a plan. The ACA also requires that starting in 2016, any employer with 50 or more employees (100 or more employees in 2015), must either offer health insurance to their employees, provide them with a stipend to purchase insurance on the marketplaces, or face tax penalties.

Prior to the ACA, pre-existing condition exclusions often created a significant barrier to insurance access in the private market. Pre-existing conditions such as pregnancy, cancer, or genetic birth defects would automatically trigger denial of an application for insurance, leaving the person to seek Medicaid (if within the income limits), forgo care, or cover the costs on their own. Now, under the ACA, pregnant women may purchase insurance to help pay for prenatal care, and labor and delivery costs. CYSHCN with genetic birth defects may also better access critical and often costly health care.

Coverage of Preventive Health Services

Another significant way the ACA impacts maternal and child health is by requiring that insurance cover (with no cost-sharing to the patient) certain preventive health services for women and children. Annual well-woman exams, critical to reproductive health, are now covered at 100%, and include such services as cervical cancer screening, sexually transmitted disease screening and counseling, and contraceptive methods counseling. Additionally, the law requires coverage for key pre- and perinatal health services, crucial to the prevention of birth defects and other childhood illness, such as gestational diabetes screening, folic acid supplements, tobacco use screening, interventions, expanded counseling for pregnant users including lactation support and counseling, and breastfeeding equipment.

The ACA's coverage provisions also provide an opportunity to identify and treat certain disorders earlier among children by requiring that insurance cover all thirty-one newborn screenings on the Recommended Uniform Screening Panel (if one's state does not already require testing for all of them). Additionally, all costs for services associated with well-child visits must be covered by insurance, including physical exams, immunizations, hearing and vision screenings, and developmental and behavioral screenings. However, it is important to note that until, or unless, they make a significant change to their benefits or costs, grandfathered plans are exempt from these coverage requirements. Title V programs could educate the public about the availability, and encourage use, of these no-cost services, as well as inform the public about the continued costs of these services under grandfathered plans.

Care Coordination & Community Benefit

The ACA also supports a number of promising care coordination initiatives that could help to improve maternal and child health. Key initiatives include Accountable Care Organizations (ACOs), medical homes, home visiting programs, and use of community health workers. ACOs are collaborations of hospitals, doctors, and other health care providers who have committed to taking responsibility for the cost, quality of care, and health outcomes of a particular patient group. They work to: "improve care transitions, ensure patient safety, enhance the patient and caregiver experience, improve health outcomes, and help patients achieve wellness goals" (White et al, 2013), as well as improve efficiency and quality of care (for example by eliminating unnecessary duplication of services, and medical errors). An ACO's payment structure is formatted so that when it delivers high-quality, cost-efficient health care, the provider members share in the savings to health care costs, either through reimbursements or other incentive payments. ACOs may be tailored to deal with a specific maternal or child population or illness. For example, there are ACOs that include well-child visits, asthma control, or prenatal care in their outcome measures. The ACA also created a specific Pediatric ACO demonstration project, which authorized participating states to recognize pediatric medical providers as an ACO for purposes of receiving incentive payments for Medicaid or CHIP savings and positive outcomes. Although CMS and state Medicaid programs have been some of the big ACO funders thus far, ACOs are not limited to government payors – private insurance companies have also been very active in creating ACOs with partnering physicians and hospitals.

The ACA's Medicaid Health Homes program, supported by federal planning grants, has created a State Plan option to provide health homes for Medicaid enrollees with chronic conditions. The program seeks to encourage provider-family partnerships in order to provide coordinated, quality care, efficiently utilize resources, and minimize costs. Individual states determine the program's payment methodology, and may tier payments to reflect the severity or number of patient's chronic conditions and the specific capabilities of the health home. Health homes have been particularly useful for coordinating the care of children with special needs, as well as pregnant women to decrease the prevalence of and costs associated with negative birth outcomes. Colorado's Title V program played an instrumental role in creating, with legislative backing, CYSHCN health homes for their Medicaid population.

The ACA also provides direct community supports for maternal and child health through the Maternal, Infant, and Early Childhood Visiting Program (MIECVP), nurse home visiting services, and community health workers (CHWs). Multiple state agencies and programs such as public health, Medicaid, and Title V programs, as well as local actors, should join together to take advantage of these opportunities. MIECVP offers federal grants to states to strengthen Title V activities, improve coordination of maternal and child health services in at-risk communities, and provide comprehensive maternal and child health services to improve outcomes for at-risk families. The ACA also established optional State Plan coverage of “nurse home visiting services” under Medicaid and CHIP. In states that have added this option, nurse home visiting programs can apply for authorization and be reimbursed by Medicaid for their services. CHWs are another type of health worker who work within communities and can influence maternal and child health. CHWs typically live within or are otherwise closely tied to the communities they serve, and act as a liaison between health and social services and community members, facilitating access to services and cultural competency. The ACA has promoted the use of CHWs in multiple ways, including establishing a CHW grant to promote the workforce, authorizing community transformation grants that can support CHWs, and encouraging CHW reimbursement under Medicaid.

The ACA also created a new requirement that, in order for non-profit hospitals to retain their 501(c)(3) tax-exempt status, every three years they must conduct a community health needs assessment (CHNA) that contains an implementation strategy for improving the health of their surrounding community. The community benefit requirements also specify that non-profit hospitals allow for greater transparency in their decision-making processes, and include more community input, particularly from low-income, minority, and underserved community members. Many hospitals’ CHNAs have already included maternal and child health data in their assessments, goals and programs within their implementation strategies, and are utilizing state and local public health and Title V program expertise. Additionally, through the new CHNA requirements, hospitals are now incentivized to not only invest in programs providing direct health provisions, but also to invest in multi-sector community partnerships and activities such as workforce development, built environment and housing, education, and economic development.



As a Title V professional, how does your situation relate to what is described above about the ACA? Enter your observations in the open entry area below. Some questions are provided to get your thinking started.

Question: *How can Title V professionals identify and monitor improvements to maternal and child health outcomes resulting from health system transformation?*

How does your situation relate to what is described above in the ACA? Are you providing direct services now or should it be a part of your strategy to provide them over the next three to five years? Will there be a market for these services? Who else in your community provides these services? Is there opportunity for partnership or a coordination role for MCH? Should your strategic plan include expansion of population-based services or increased leadership in building a supportive community infrastructure for supporting families?

Your Observations:



Step 3: Think about the Feasible Options and Select One to Begin Your Analysis

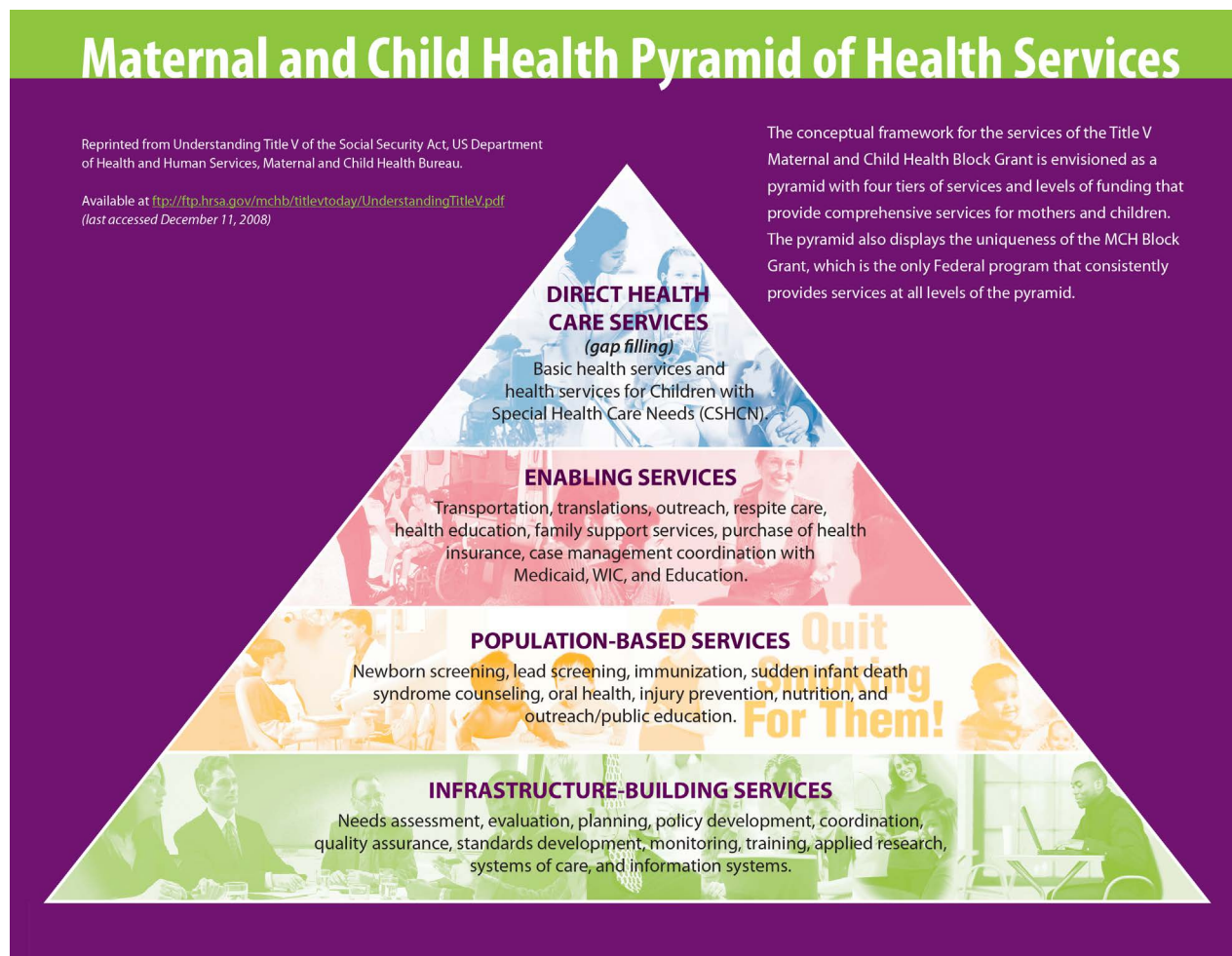
There could be many ways for Title V professionals to identify and monitor improvements to maternal and child health outcomes resulting from health system transformation. A technical way of answering the question might be to simply think about whether or not you will provide the services and how much funding you will get in the future. A more adaptive way to reframe this question might be:

“How can Title V professionals leverage ACA opportunities to broker improvements for the well-being of mothers and children, including those with special needs?”

Four options, based on the Maternal and Child Health Pyramid of Health Services, are presented to help you think about how you might approach the question. In everyday application, you may need to combine more than one option; however, for this practice, choose only one. Read and consider each option and then record your response in the **Your Turn** section.

The Maternal and Child Health Pyramid of Health Services

The conceptual framework for the services of the Title V Maternal and Child Health Block Grant is envisioned as a pyramid with four tiers of services and levels of funding that provide comprehensive services for mothers and children. The pyramid also displays the uniqueness of the MCH Block Grant, which is the only Federal program that consistently provides services at all levels of the pyramid.⁵



Option 1:

Continue to provide direct health care services to women and children, including children with special health care needs.

Evaluate your capacity to provide direct health care services for the MCH population. Think about your opportunities around serving as a medical home particularly for underserved sub-populations, and providing health-related services, including prevention, primary care and specialty care services, when needed. Additionally consider how to sustain these efforts, such as newly added insurance options resulting from health reform.

Example: *Rhode Island developed a health home state plan amendment that establishes existing Comprehensive Evaluation Diagnosis Assessment Referral Re-evaluation (CEDARR) Family Centers as health home providers for children with special care needs. Although CEDARR Family Centers have supported families of children with special care needs and provided direct therapeutic services since 2001, the ACA's home health funding allowed for: enhanced screening of secondary conditions (e.g., obesity and depression); additional reimbursement to primary care providers to participate in care planning; information technology improvements; and better communication between the Centers and Medicaid managed care plans. Rhode Island created operational protocols to define collaborative roles for home health providers and health plans.⁶*

Option 2:

Work across agency boundaries to provide access to enabling services.

Assess your capacity to provide or facilitate services for the MCH population that enable their access to care. Think about your opportunities regarding enabling services, including: financial access, cultural acceptability, accessibility of primary care, specialty care, and rehabilitation services. Specific services may be translation services, respite care, health education, and case management coordination with Medicaid.

Title V programs may want to assist the populations they serve in understanding the various insurance options available to them and ensure that they sign up for the most appropriate choice. For those who still find insurance to be unaffordable or unobtainable, Title V programs may continue direct them to appropriate safety net services. Alternately, Title V programs could get directly involved with health insurance marketplaces, in monitoring and providing advice regarding provider networks, and coverage provisions that may affect maternal and child health.

Example: *Starting in July 2013, Colorado Medicaid's Accountable Care Collaborative (ACC) incorporated well-child visits (children under 18) as one of their four key performance indicators to measure improvement among members. In FY 2013-14, the ACC performance measure focused on children ages 3-9 years. The ACC currently serves about 60% of state Medicaid clients. In addition to their regular Medicaid benefits, ACC members belong to a Regional Care Collaborative Organization (RCCO), which helps to coordinate their care, connecting them with primary care medical homes, specialists, and community resources. RCCOs and primary medical care providers that demonstrate regional improvement in well-child visits are able to share in quarterly incentive payments. The Colorado ACC has already produced positive outcomes for FY2013-14: the program's net savings was approximately \$31 million, and about half of all ACC children received a well-child visit.⁷*

Option 3:

Facilitate efficient and effective provision of integrated population-based services.

Explore your involvement in the direct management of population-based services and programs; coordination with other agencies and organizations (universities, managed care organizations, physician groups) in the provision of these services; and funding mechanisms for these services. Population-based services provided for Title V population groups include screenings, immunizations, oral health, and outreach efforts.

Example: *The ACA makes children's oral health care an "essential benefits package" that is offered in state health insurance marketplaces. By 2017, oral health will be considered an essential benefit for all coverage, inside or outside the marketplace system. Additionally, the law requires the Secretary to establish a 5-year, evidence-based public education campaign to promote oral health, including a focus on early childhood caries, prevention, oral health of pregnant women, and oral health of at-risk populations.⁸*

The Georgia Oral Health Coalition (GOHC), formed by the Georgia Department of Public Health, works to prevent oral disease among Georgians. The coalition has been instrumental in addressing oral health infrastructure and policy for the state due to the collaboration between partners such as: public health, dental associations, pediatric associations, schools, and health educators. The GOHC educates stakeholders on oral health literacy, disseminates oral health information, promotes oral health surveillance activities, reviews access to dental services, and supports policy for positive dental service activities.

GOHC was strengthened by early wins that demonstrated the critical role it played in dental health policy. Now, policy-related work has been initiated in several areas including: public health dental hygiene supervision, as well as Medicaid reimbursement for medical practices for oral screenings, anticipatory guidance, and fluoride varnish applications.⁹

Option 4:

Take or assume a leadership role in building and developing supportive infrastructure for systems serving mothers and children.

Examine your capacity to promote comprehensive systems of services through infrastructure building. Think about how local delivery systems meet the population's health needs. Assess your role in planning, evaluation, research; policy development; workforce development; the monitoring of continuous quality improvement; and the development and implementation of standards of care.

Example: *Under the ACA, charitable hospitals with 501(c)(3) status are required to complete Community Health Needs Assessments (CHNA) and adopt implementation strategies to improve community health. State and local public health agencies are also required to complete community health assessments and develop community health improvement plans in order to be accredited. These requirements can provide the opportunity for win-win collaborations between public health and hospitals.*

In Venango County, Pennsylvania, the University of Pittsburgh Medical Center (UPMC) Northwest partnered with state agencies and clinics, university researchers, community health care providers (including Title V clinics), and other community partners on their CHNA and implementation plans. The CHNA identified maternal and infant health as one of its three key areas for intervention. The CHNA found that Venango County had lower rates (than the state and nation), of first trimester prenatal care and higher rates (than the state) of smoking during pregnancy. The UPMC Northwest CHNA maternal and infant health implementation strategies, developed with the hospital and its partners, include hospital-based educational classes (on childbirth, infant care, breastfeeding, and sibling interaction), community clinic programs (on nutritional counseling, transportation assistance, parenting classes and substance abuse prevention), and a home visiting program for at-risk families.¹⁰



Which of the four options presented above is the most appealing to you as you think about your organization over the next three to five years? Why? Enter your observations in the space below.

Question: *How can Title V professionals leverage ACA opportunities to broker improvements for the well-being of mothers and children, including those with special needs?*

Choose one preferred option:

- Option 1:** Continue to provide direct health care services to women and children, including children with special health care needs.
- Option 2:** Work across agency boundaries to provide access to enabling services.
- Option 3:** Facilitate efficient and effective provision of integrated population-based services.
- Option 4:** Take or assume a leadership role in building and developing supportive infrastructure for systems serving mothers and children.

Why is this option your preferred choice for your organization for the next three to five years?



Step 4: Apply Adaptive Actions

The ACA presents dozens of adaptive challenges for public health leaders and practitioners. By their very nature, these challenges have no ready answer or response. Public health practitioners must learn as they go, making sense of what is happening as it unfolds and adjusting accordingly.

In the fall of 2010, Georgia Health Policy Center researchers conducted 15 health reform strategic assessments with public health departments, state department staff, community-based organizations, large and small provider practices, and large and small employers.¹¹ Eight strategic actions emerged from the work and can be applied here to help you think about a number of adaptive health reform challenges.

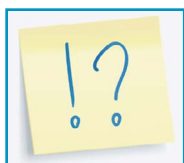


Influencing Decisions

Many of the decisions for implementing the ACA will occur at the state level and have not yet been made, creating a tremendous opportunity for public health to influence policymakers and service providers through community forums, social media, responding to government “requests for comments,” being networked to information, and convening diverse stakeholder groups.

Educating Others

Public health leaders understand the ACA to varying degrees and at different levels, and those who understand more about the law and its potential impact on public health have the opportunity to educate others at the state and local levels. Public health is viewed as a community leader, and the opportunity exists for public health to play a role in convening stakeholders in order to understand better how the ACA will impact potential partners. In this role, public health can share what is known about the opportunities the ACA creates for improving the community’s health. In the process of educating others, information should be neutral, simple, accurate, and accessible to all.



Planning Under Uncertainty

Because the changes in the health reform law will take place over several years, public health leaders are faced with the daunting prospect of making decisions without complete information.

In addition, they are acutely aware that the provisions of the law itself might change. It is often said that jazz musicians listen to what is being played and play what is missing. Like jazz musicians, strategic thinkers must be improvisational in their thinking and planning. Some ideas to help public health leaders plan under uncertainty include identifying the most likely scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of reform; building good information systems to track progress and identify needed adjustments; and looking for “win-win” opportunities that can be created through collaboration with multiple partners.



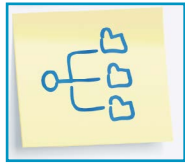
Staying Abreast of New Information

Given the length and complexity of the ACA, it is challenging to stay on top of all the regulations, administrative decisions, and guidance that has been, and will continue to be, issued from various sources. Even more difficult is sorting out what this information means and how it should be used. Still, adaptive thinkers must seek out the latest information related to the challenges they are facing. Some sources of new information related to the ACA include the Federal Register, national association Web publications, healthcare.gov, listservs, and information clearinghouses at the state level. To better utilize these sources, dedicated staff is sometimes needed for research opportunities, supportive infrastructure, grant writing capacity, and the ability to benchmark progress. Since most organizations cannot dedicate staff to all of these functions, partnership is all the more important.

Creating New Partnerships

New collaborations are critical to the success of health reform. Some of the partnerships needed to implement health reform may involve coalitions among public health, community health centers, provider communities, hospitals, businesses, universities, social service organizations, community-based organizations, the faith-based community, state and local government authorities, senior centers, and others. Effectively forging such partnerships requires a neutral, respected convener who is ideally not an entity that stands to directly benefit from the partnership.

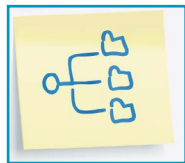




Building Workforce Capacity

The elimination of copays, deductibles, and coinsurance for many preventive services will likely increase the demand for providers in both the public health and private workforces. Particularly for

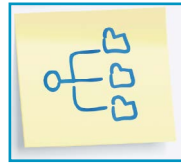
the public health workforce, this will depend on the various health reform opportunities public health agencies pursue.¹²⁻¹⁸ Meeting the workforce shortfall may require incentives to retain providers in needed locations, educational initiatives to ensure the pipeline produces providers that match workforce needs, the provision of technology training and education, and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers. The Association of State and Territorial Health Officials' (ASTHO) analysis of workforce enhancements in the ACA is a good resource.¹⁹



Building Information Technology Capacity

The ACA will further stimulate demand for electronic records and other health data and increasingly require complex data sharing systems. Institutional information

technology needs and requirements vary and reflect the idiosyncratic and unique nature of organizations. The most likely information technology capacity needs related to the ACA will involve designing or purchasing patient management and clinical management systems, sharing data among systems, building systems that can accommodate the increase in anticipated volume of claims and provider information, and developing data system standards for health. Public health agencies may want to consider becoming repositories for surveillance data and other public health information. A part of that creation might include capacity for quality measurement at the population level.



Building Care Coordination Capacity

The ACA includes a number of features for improving coordination of care, including a requirement that health insurance exchanges contract with professional associations and local organizations

to provide exchange navigator services; funding to support improved care transition services for high-risk Medicare beneficiaries; establishment of community-based, interdisciplinary care teams; and grants to support comprehensive, coordinated, and integrated health care services for low-income populations. To build capacity for care coordination, organizations will need to understand the administrative requirements; be able to link different types of care; influence decisions about health reform; assist health networks in obtaining pertinent information (perhaps surveillance information); and obtain the technical ability to collect information.



So far, you have described how your organization might identify and monitor improvements to maternal and child health outcomes in the context of the ACA, you have selected one option for possibly moving forward, and you have documented why that option resonates with you or your organization. Now you have the opportunity to think about strategic actions related to the option you selected. If you were going to pursue an option related to maternal and child health, which strategic actions would you consider implementing and why? Record your answers in the table below.

Question: *How can Title V professionals leverage ACA opportunities to broker improvements for the well-being of mothers and children, including those with special needs?*

Your choice:

Option 1: Continue to provide direct health care services to women and children, including children with special health care needs.

Option 2: Work across agency boundaries to provide access to enabling services.

Option 3: Facilitate efficient and effective provision of integrated population-based services.

Option 4: Take or assume a leadership role in building and developing supportive infrastructure for systems serving mothers and children.

Some questions about each adaptive action are provided below to get your thinking started.

Influencing Decisions:

Where are the leverage points for influencing decisions related to your question? Who can you engage to influence those decisions?

Educating Others:

Who needs to know about your situation related to health reform? What are the facts? How will you communicate them?

<p>Planning Under Uncertainty:</p> <p>What are the most likely scenarios related to your question and how can you use them as a foundation for planning? What are the information systems you might need to access or build?</p>	
<p>Staying Abreast of New Information:</p> <p>How will you learn of changes in the ACA related to your question? What partnerships can you leverage to do this?</p>	
<p>Creating New Partnerships:</p> <p>What new partnerships might advance your strategy? Who can serve as a neutral convener of these new partnerships?</p>	
<p>Building Workforce Capacity:</p> <p>Will you need new types of workers or more workers to achieve your goals? How can you ensure there will be sufficient capacity?</p>	
<p>Building Information Technology Capacity:</p> <p>What sort of IT capacity will you need to achieve your goals? Are there partnerships you can leverage to expand or create this capacity?</p>	
<p>Building Care Coordination Capacity:</p> <p>How will you transition from providing services to coordinating services or adding coordination to the existing provision of services? What partners will be necessary? What certifications will be required?</p>	



Step 5: Simplified Implementation Plan

The last step in thinking adaptively about questions related to health reform is creating a simplified implementation plan for the way in which you have chosen to respond to your original question and the adaptive actions that will help you get there. Thinking about three fundamental factors for the actions you wish to take will help you to gain clarity about what is feasible: staffing, budget and a funding strategy, and a management plan. The CDC has several resources on program planning, improvement, and evaluation that can be found at <http://www.cdc.gov/stltpublichealth/> program.

Staffing



The staff responsible for program implementation and the partners who provide program guidance are key factors in the ultimate success

or failure of a new venture. In planning for implementation, it is important to determine the most effective structure for program continuation.

During this step of the planning process, you will want to assess different aspects of your program and determine what changes may be needed to achieve maximum efficiency. This can be a difficult conversation because you may have to make hard decisions about how many and which staff will be needed to support the activities that you want to initiate. Most likely, you will want someone from outside your program staff to facilitate this conversation.

Some questions that may help you think about staffing are: What expertise is needed to initiate this activity? Can some of the activities be absorbed by our partners? Can any activities be undertaken by volunteers rather than paid staff? What paid staff will be necessary to initiate our activities? Who will employ the paid staff? Are there any union bargaining rules that must be considered?



Budget and Funding Strategy

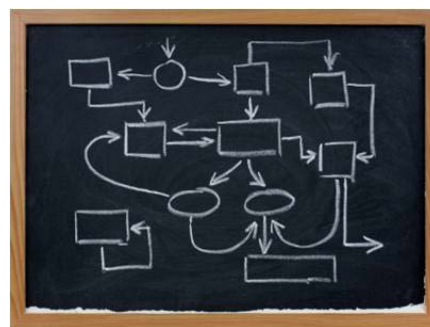
Having a clear idea of the cost of sustaining your activities is an essential part of the implementation planning

process. You may want to project your costs for a minimum of three years so you get a complete picture of the total cost of the activity, including one-time cash expenditures, on-going operational expenses, etc. Developing a line item budget for each activity is necessary for determining your funding strategy.

Sources of funding include grants, government budgets, contributions or sponsorships, revenue from events, earned income and dedicated sources such as fees, indirect funding sources such as in-kind services and volunteerism, and the redirection of existing funding that may result from new efficiencies or other activities. As you think about these types of funding streams, also think about the local sources of funding available to you within each category. Brainstorm with your partners to make a list of possible funders/supporters for your actions. Be as specific as possible. For instance, do not list "businesses." Instead, include the names of actual businesses in your community that you can contact for support.

Sustainability heavily depends on diversification of funding sources. You will want to identify potential sources from a variety of methods. Remember that many activities are sustained through partnerships. As a part of your sustainability planning process, you should discuss the role that your partners can realistically play in the long-term support of your actions.

Management Plan



How you manage new activities and the staff and partners who will undertake them is an important part of your simple implementation plan. Some questions that will help get you started thinking

about a management plan include: What has worked well in managing your current activities and relationships? What could be improved? What management functions will be required of your new actions? What is the best strategy for managing these functions? Do you need to employ a project coordinator or can the coordination role be handled by your staff or undertaken by partners?



The last step in thinking adaptively about your questions about health reform is creating your own simplified implementation plan for the option you have chosen to address your question and adaptive actions that will help you get there. Now you will create your implementation plan by answering the questions below.

Question: *How can Title V professionals leverage ACA opportunities to broker improvements for the well-being of mothers and children, including those with special needs?*

Your choice:

Option 1: Continue to provide direct health care services to women and children, including children with special health care needs.

Option 2: Work across agency boundaries to provide access to enabling services.

Option 3: Facilitate efficient and effective provision of integrated population-based services.

Option 4: Take or assume a leadership role in building and developing supportive infrastructure for systems serving mothers and children.

Staffing

What expertise is needed to initiate this activity?	
Can some of the activities be absorbed by your partners?	
Can any activities be undertaken by volunteers rather than paid staff?	
What paid staff will be necessary to initiate your activities?	

Who will employ the paid staff?	
Budget and Funding Strategy	
What is the three-year cost for this activity?	
What are the one-time expenditures?	
What are the ongoing operational expenses?	
What are your possible funding sources?	
What community partners can be approached for direct or indirect support?	
Management Plan	
What has worked well in managing your current activities and relationships?	

What could be improved?	
What management functions will be required of your new actions?	
What is the best strategy for managing these functions?	
Do you need to employ a project coordinator or can the coordination role be handled by your staff or undertaken by partners?	

You have now completed the five steps that will help you practice shifting your thinking from a technical perspective to a more adaptive perspective. The steps are:



Step 1: Define your question. What is it that you want to know? Is the question unique to your organization or do you think it might apply to others?



Step 2: Collect information about your question related to the Affordable Care Act and health system transformations. What exactly is written in the law? You may have to go directly to the law or read what others have said related to the law and your question. Are there new approaches or ways of thinking about your question being practiced in other states? Chances are you will be able to learn something about your question from others. Gathering information from the law is one place to start. You may want to collect additional state and local information.



Step 3: Think about the feasible options and select one to begin your analysis. When you think about your question, what are the possible ways you could answer the question?



Step 4: Apply adaptive actions related to your question. The planning tool describes eight adaptive actions you can apply to the answer option you choose. Some might be very relevant to your work and others may not.



Step 5: Create a simplified implementation plan. This step will help you think about a concrete way to move forward related to staffing, budgeting and funding, and a management plan in the context of how you choose to answer your question.

This process can be used with any challenging question for which there may not be a ready-made solution — not just questions about health reform. The process takes time, but it can lead to a higher level of thinking than merely reaching for the easier, technical solution.

Bibliography

1. <https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf>. Accessed online January 21, 2015.
2. William S. Custer, Ph.D., Center for Health Services Research, Institute of Health Administration, J. Mack Robinson College of Business, Georgia State University, 2013.
3. Heifetz, Ronald A., & Linsky, M. (2004). When Leadership Spells Danger. *Educational Leadership*. 61.7 (April 2004: 33-37).
4. <http://www.pewresearch.org/fact-tank/2014/11/18/5-facts-about-illegal-immigration-in-the-u-s>. Accessed online December 30, 2014.
5. <http://www.mchb.hrsa.gov/programs/index.html>. Accessed online January 8, 2015.
6. <http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/effect-of-provider-payment-refor.html>. Accessed online January 8, 2015.
7. <https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%20News%20Release%20and%20Fact%20Sheet%20-%20November%203,%202014.pdf> and [https://www.colorado.gov/pacific/sites/default/files/Medicaid%20Program%20News%20and%20Updates%20\(B1300339,%20July%202013\)_0.pdf](https://www.colorado.gov/pacific/sites/default/files/Medicaid%20Program%20News%20and%20Updates%20(B1300339,%20July%202013)_0.pdf). Accessed online January 8, 2015.
8. <http://www.oralhealthwatch.org/policy-center/healthcare-reform-and-oral-health>. Accessed January 19, 2015.
9. <https://practicalplaybook.org/success-story/georgia-promotes-oral-health>. Accessed January 19, 2015.
10. <http://www.upmc.com/about/community-commitment/Documents/northwest-community-health-needs-assessment.pdf>. Accessed online January 8, 2015.
11. Georgia Health Policy Center. (2011). *Health Reform: From Insights to Strategies, A Variety of Perspectives*. <http://ghpc.gsu.edu/download/health-reform-from-insights-to-strategies-a-variety-of-perspectives>. Accessed online December 29, 2014.
12. <http://bhpr.hrsa.gov/shortage>. Accessed online November 17, 2011.
13. Hunsaker, M., & Kantayya, V. S. (2010). Building a Sustainable Rural Health System in the Era of Health Reform. *Disease-a-Month*, 56(12), 698-705.
14. Kapp, M. (2011). Conscripted physician services and the public's health. *The Journal of Law, Medicine & Ethics*, 39(3), 414-424.
15. Long, S., & Masi, P. (2009). Access and affordability: an update on health reform in Massachusetts, fall 2008. *Health Affairs*, 28(4), W578-W587.
16. Pande, A., Ross-Degnan, D., Zaslavsky, A., & Salomon, J. (2011). Effects of Healthcare Reforms on Coverage, Access, and Disparities: Quasi-Experimental Analysis of Evidence from Massachusetts. *American Journal of Preventive Medicine*, 41(1), 1-8.
17. Paradise, J. (2011). *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.
18. Wilson, J.F. (2008). Primary Care Delivery Changes as Nonphysician Clinicians Gain Independence. *Annals of Internal Medicine*, 149(8), 597-600.
19. ASTHO. (2010). *Summary of Health Care Workforce and Primary Care Provisions, Patient Protection and Affordable Health Care Act*. Retrieved on February 12, 2013 from <http://www.astho.org/Programs/Health-Reform/Policy-Analyses/Health-Care-Workforce-and-Primary-Care-Provisions-in-PPACA/>.



National **MCH** Workforce
Development Center
Advancing Health Reform Implementation

National MCH Workforce Development Center

Department of Maternal and Child Health
Gillings School of Global Public Health
The University of North Carolina at Chapel Hill
Campus Box 7445
Chapel Hill, NC 27599
(919) 966-6290
<http://mchwdc.unc.edu>



Georgia Health Policy Center

Andrew Young School of Policy Studies
Georgia State University
14 Marietta Street, NW, Suite 221
Atlanta, GA 30303
(404) 413-0314
www.gsu.edu/ghpc



National Network
of Public Health Institutes

National Network of Public Health Institutes

1515 Poydras Street, Suite 1200
New Orleans, LA 70112
(504) 301-9811
www.nnphi.org